EHR Medicaid Incentive Payment Program Toolkit

March 10, 2015

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1 INTRODUCTION

The EHR Medicaid Incentive Payment Program will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. This guide covers the Illinois Electronic Health Record Payment Incentive Program attestation process.

1.1 Resources

1.1.1 Websites

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule
  - **Stage 1 Final Rule**
  - **Stage 2 Final Rule**
  - **2014 Modifications (Flexibility Rule)**
- EHR Medicaid Incentive Payment Program system (eMIPP) Portal located at: **https://medicaid.illinois.gov**
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at **http://www.cms.gov/EHRIncentivePrograms/**
- Office of the National Coordinator for Health Information Technology located at **http://www.healthit.gov/providers-professionals**

1.1.2 Regional Extension Centers

The U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, has awarded two Illinois applicants with Regional Extension Center (REC) grants. The federal REC program (officially known as the Health Information Technology Extension Program) was developed to assist health professionals in implementing and becoming "meaningful users" of electronic health records.

The two REC awardees are: ILHITREC, a consortium led by Northern Illinois University, serving all areas of Illinois outside the 606 Zip codes; and CHITREC, a consortium led by Northwestern University, serving the city of Chicago. The two Illinois RECs provide outreach and support services to thousands of primary care providers and hospitals, throughout the state. The RECs provide a full range of assistance related to EHR selection and training.

The Illinois Office of Health Information Technology is working cooperatively with these RECs to coordinate resources and achieve the state's goals for health information technology. The REC websites are listed below:

IL-HITREC (Statewide Consortium)
www.ilhitrec**.org**
P.O. Box 755, Sycamore, IL 60178
Phone: 815-753-1136
Fax: 815-753-2460
Email: info@ILHITREC.org

CHITREC (Chicago Consortium)
http://chitrec.org/
750 N. Lake Shore Drive, 9th Floor
Chicago, Illinois 60611
Phone: 312.503.2986
Fax: 312.503.6743
Email: info@chitrec.org

2 BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at http://www.healthit.gov/providers-professionals/ehr-incentives-certification

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Illinois Department of Healthcare and Family Services (HFS) will work closely with federal and state partners to ensure that the Illinois Medicaid EHR Incentive Program fits into the overall strategic plan for the Illinois Health Information Exchange (HIE), thereby advancing national and Illinois goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the CMS Medicare and Medicaid Registration and Attestation System (RAS), CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at **http://www.cms.gov/EHRIncentivePrograms/**. The site provides general and detailed information on the programs, including tabs on meaningful use, clinical quality measures, certified EHR technology, payment adjustments and hardship exceptions, Stage 2 and frequently asked questions.

3 ELIGIBILITY

EPs must begin the program no later than calendar year (CY) 2016 and EHs must begin by Federal Fiscal Year (FFY) 2016. The first tier of provider eligibility for the EHR Medicaid Incentive Payment Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the IL MMIS provider data base does not correspond to the provider types and specialties approved for participation in the EHR Medicaid Incentive Payment Program, the provider will be notified of disqualification.

The following providers and hospitals are potentially eligible to enroll in the EHR Medicaid Incentive Payment Program:

EP Type and Specialty	EH Type and Specialty
• Physician • Physician Assistant (practicing in a FQHC or RHC led by a Physician Assistant): An FQHC or RHC is considered to be PA led in the following instances: o The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic) o The PA is the clinical or medical director at a clinical site of the practice o The PA is the owner of the RHC • Pediatrician: Any provider who is Board Certified as a Pediatrician or has at least 90% of Medicaid Recipients Under the Age of 21. • Nurse Practitioner • Certified Nurse Midwife • Dentist • Optometrist	• Acute Care Hospital • Children's Hospital • Critical Access Hospital

Note: Some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the EHR Medicaid Incentive Payment Program.

3.1 Additional requirements for the EP

To qualify each year for an EHR incentive payment , the EP must:

1. Meet one of the following patient volume criteria in any 90 consecutive days during the preceding calendar year or twelve months prior to the attestation date:
   a. Have a minimum of 30 percent patient volume attributable to individuals receiving Medicaid funded services; or
   b. Have a minimum 20 percent patient volume attributable to individuals receiving Medicaid funded services, **and** be a pediatrician (for the purposes of the Illinois EHR Medicaid Incentive Payment Program, a pediatrician is defined as Medicaid enrolled provider who serves 90% of patients under the age of 21 based on the age of the patient at the time the service is rendered or a Medicaid enrolled provider with a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics or American Osteopathic Board of Pediatrics); or

c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals (For this program, practicing predominantly in an FQHC/RHC means 50% or more of the total patient volume for the EP over a six-month period is at an FQHC/RHC).

2. Have no sanctions and/or exclusions.
3. Not be deceased.
4. Not have 90% or more of the patient encounters take place in a hospital setting.
5. Be enrolled and in good standing with Illinois Medicaid.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment ("payee") is required when registering with CMS Registration and Attestation System (RAS) and must match a TIN linked to the individual provider in the Department of Healthcare and Family Services (HFS) provider database. The system will check for the following:

- Provider is enrolled with HFS
- Provider status is active
- Provider/Payee combination is valid
- Provider is enrolled with HFS in an eligible Provider Type
- Provider is not sanctioned
- Provider is not deceased

If any of the checks performed above fail, the provider will not be able to attest. Please contact the REC Help Desk Phone 1-855-MUHELP1 (or 1-855-684-3571) or HFS' EHR Team for assistance by calling: 1-877-782-5565, Option 8.

3.2 Additional requirements for the EH

To qualify each year for an EHR incentive payment, the EH must be:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume in the previous Federal Fiscal Year (FFY) for each year the hospital seeks an EHR incentive payment; or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers (90% or more of their patient encounters take place in a hospital setting) are not eligible for the EHR incentive program.

3.3 Qualifying Providers by Type and Patient Volume

Providers by Type	Minimum Percent Patient Volume (90-day period)	
Physicians	30%	Or the Medicaid EP practices predominantly in a FQHC or RHC with 30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's Hospital	No minimum	

3.4 Out-of-State Providers

The EHR Medicaid Incentive Payment Program welcomes any out-of-state provider to participate in this program as long as they are enrolled in Illinois Medicaid. Illinois must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit. Records must be maintained as applicable by law in the state of practice or Illinois, whichever is deemed longer.

4 ESTABLISHING PATIENT VOLUME

An Illinois Medicaid provider must meet patient volume requirements annually. The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (Children's Health Insurance Program).

There are several items to be considered when calculating Medicaid patient volume, including:

- Methodology for determining patient volume
- Individual volume vs. group proxy
- Out-of-state encounters

4.1 Methodology for Determining Eligible Professional Patient Volume

All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on encounters with Medicaid (billed to HFS) and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in a FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

4.1.1 Definition of an Eligible Professional Medicaid Encounter

For purposes of calculating EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an individual where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

It also includes Managed Care Organization encounters and Dual Eligible (Medicare/Medicaid) encounters.

4.1.2 Definition of an Eligible Professional Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in a FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Billed to HFS;
- Furnished by the provider as uncompensated care (charity care); or
- Furnished at either no cost or reduced cost based on a sliding fee scale determined by the individual's ability to pay.

4.1.3 Calculating Eligible Professional Patient Volume

To calculate patient volume, providers must include a ratio where the numerator is the total number of Medicaid (billed to HFS) patient encounters (or needy individuals for FQHCs and RHCs) treated in any 90-day period in the previous year or the twelve months prior to the attestation date , and the denominator is all patient encounters over the same period. The numerator must consist of all encounters billed to HFS during the 90-day period; the denominator must consist of all encounters billed to any entity during the 90-day period.

To calculate Medicaid patient volume, EPs (except those practicing predominantly in a FQHC/RHC) must divide:

- The total Medicaid encounters billed to HFS or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year or twelve months prior to the attestation date; by
- The total patient encounters in the same 90-day period.

$$\frac{\text{Total Medicaid Member Encounters billed to HFS in any 90-day period in the preceding calendar year or twelve months prior to the attestation date}}{\text{Total Patient Encounters in that same 90-day period}} * 100 = \%\textit{Medicaid patient volume}$$

To calculate needy individual patient volume, EPs practicing predominantly in a FQHC/RHC must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year or twelve months prior to the attestation date; by
- The total patient encounters in the same 90-day period.

4.1.4 Individual vs. Group Patient Volume

Medicaid patient volume thresholds may be met at the individual level (by provider NPI) or at the group practice level (by organizational NPI/TIN). EPs may attest to patient volume under the individual calculation or the group/clinic calculation in any participation year.

4.1.4.1 EPs Using Individual Patient Volume

For EPs calculating individual patient volume, the numerator must consist of all encounters billed to HFS. Following is an example of how the EP will calculate the Medicaid patient volume:

> *Dr. Smith reviews the encounters in his practice management system and determines that, for a 90-day period from October 1, 2012 – December 29, 2012, he has 500 paid claims/accepted encounter data for HFS recipients and his total volume of encounters for this period is 1,000.*

$$\frac{\text{500 encounters billed to HFS}}{\text{1,000 total encounters}} * 100 = \text{50\% Medicaid Patient Volume}$$

4.1.4.2 EPs Using Group Patient Volume Method

EPs may use a clinic or group practice's patient volume as a proxy for their own under these conditions:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation).
- There is an auditable data source to support the clinic's patient volume determination.
- All the EPs in the group practice use the same methodology for the payment year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).
- The clinic or practice must use the entire group's patient volume and not limit it in any way.
- If the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice and not the EP's outside encounters.

The following is an example of how an EP would use the group patient volume method:

> ***Example #1*** *Dr. Sue, a physician practicing in pediatrics, works for ZZ Clinic, YY Clinic and individually. She alone has 19% patient volume therefore does not qualify for the program.*

Professional	*Provider Type*	*Medicaid Encounters*	*All Encounters*	*Patient Volume %*
Ms. Leigh	***Dietician***	*50*	*100*	*50*
Dr. Tom	*Physician*	*34*	*100*	*34*
Dr. Sue	*Pediatrician*	*19*	*100*	*19*
Dr. Bob	*Pediatrician*	*20*	*100*	*20*
Total		*123*	*400*	***31***

In the example above the pediatricians are part of a group and if you aggregate all of the Medicaid encounters and divide by the number of members you can arrive at the group volume of 123/400 = 31% Medicaid Patient Volume.

In this example, the group maximized their benefits. Each member of the group would attest to 123 Medicaid encounters and 400 for all encounters allowing all providers in the group to attest to 30% Medicaid volume. Notice in the example above, it is appropriate when using group encounter methodology to include all licensed professionals regardless of eligibility for the program. Dieticians are excluded from participation; however their encounters can be used in calculating group volume.

The practice maximized their benefits:

a. *The practice was allowed to use all the providers encounters*
b. *Ms. Leigh is not eligible for the program, but her encounters are able to be used in the group methodology*
c. *Dr. Tom could have attested as an individual and received the same year 1 incentive of $21,250 because he has more than 30% Medicaid Patient Volume.*
d. *Dr. Sue would have not been eligible, but based on the calculation can attest and receive the full incentive of $21, 250 in her first year of participation.*
e. *If Dr. Bob would have attested individually he would have received $14,167 in their first year of the program. By utilizing the group methodology he can receive $21,250.*

Example #2

Dr. Pete is part of a large group practice with multiple locations consisting of providers that serve some Medicaid and providers that are enrolled but see no Medicaid patients. If the practice calculates the patient volume individually they have wildly varying results from 100% to 10% and would only be eligible for 70% of the clinics professionals. The practice includes professionals that are eligible for the program and some that are not. If the practice calculates the combined total of the group's patient volume based on Payee Tax ID and reaches 30% or more Medicaid utilization, then it is acceptable to use the entire practices patient volume when attesting. This is the easiest method for HFS to validate.

4.1.5 Groups – Additional Considerations

- When state adjudicators review the **first** group member for eligible encounters and find that the eligible encounter data does not meet the required threshold:
  - All members of the group are rejected or denied
  - Each member receives an email notifying them of the state action
  - If "Registration Rejected" or "Registration Denied":
    - The eligible encounter data becomes editable for all members of the group, including start date and encounters, both total and eligible.
    - The first member of the group to edit and save the data to correct it forces all other members' eligible encounter data to be read-only.
- When a group member is approved then no member of the group can be denied or rejected for patient volume eligibility.

- When patient volume reporting period "Start Date" is updated by the first provider, all existing members receive an email asking them to revalidate their membership in the group during the new reporting period.
- When "Medicaid Encounters" or "total encounters" is updated the System will send an email to all members of the group asking them to revalidate the update.
- If the first provider updates the "Include Organizational Encounters" button = YES to NO, then the group ceases to exist and the System:
    - Disenrolls all members of the group for group eligibility
    - Removes all group eCQM data that exists for each disenrolled member
    - Sends an email to each ex-member that notifies them of the following:
        - The group no longer exists
        - All eligibility information for the group has been removed.
        - All eCQM information for the group has been removed.
        - The group may be recreated by another provider
        - Each provider will have to rejoin the recreated group.
        - All group eCQM data will have to be resubmitted if the group is recreated.
        - Each provider should validate whether the MU reporting period, if created, still applies and the MU reporting period start date is now editable.
- If the group is an FQHC, then the provider who first saves the group must select "Render Care in FQHC/RHC?=YES.
    - FQHC will default to FQHC=YES for all group members and no longer be modifiable.
    - If the first (FQHC) provider later changes FQHC=NO, then the system will identify all Physician Assistants ("Practice as a Physician Assistant"=YES) and do the following:
        - Remove the group eligibility information.
        - Make the MU reporting period dates editable for this provider.
        - Send an email to the Physician Assistants that they can no longer participate as a group member for purposes of eligibility or eCQM reporting. The PA may still attest as an individual provider in an FQHC setting but not for this group.
- If a provider loses group membership because of a change in eligible encounter reporting period, or chooses to drop group membership then the system will:
    - Remove any group eCQM data that has been submitted for that provider.
    - Make the MU reporting period dates editable for this provider.
    - Wipe the org eligible encounters. The provider may use the same eligible encounter reporting period or another but must use a single practitioner's practice encounters.
- If a member of a group is rejected for MU Core or Menu objective compliance, then only that member of the group is rejected and must re-attest.

4.1.6 No-Cost Encounters

Providers have the option to include zero-pay claims in their patient volume calculation. If the provider chooses to include zero-pay claims in the calculation, they should be included in the total Medicaid encounters number and must also be separately identified during attestation.

4.1.7 Out-of-State Encounters

If you serve Medicaid patients from bordering states or if your practice location is in a border state, you may include the Medicaid patient volume from the state or location(s) only if that additional encounter volume is needed to meet the Medicaid patient volume threshold. If an EP aggregates Medicaid patient volume across states, HFS may audit any out-of-state encounter data before making the incentive

payment. The EP must maintain auditable records for the duration of the HFS Medicaid EHR Incentive Payment program.

4.2 Methodology for Determining Eligible Hospital Patient Volume

To calculate Medicaid patient volume, an EH must divide:

- The total HFS Medicaid encounters and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year or twelve (12) months preceding attestation by:

- The total encounters for all payors in the same 90-day period.
  - Total number of inpatient discharges in the representative 90-day period plus total number of emergency department visits in the same 90-day period.
  - Note that the emergency department must be part of the hospital.

4.2.1.1 Definition of an Eligible Hospital Medicaid Encounter

For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as
1) an inpatient discharge, or
2) an emergency room visit

where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

Exception – a children's hospital is not required to meet Medicaid patient volume requirements.

5 PAYMENT METHODOLOGY FOR ELIGIBLE PROFESSIONALS

The maximum incentive payment an EP could receive from Illinois Medicaid equals $63,750, over a period of six years, or $42,500 for pediatricians with a 20-29 percent Medicaid patient volume as shown below.

Provider	**EP**	**EP-Pediatrician**
Patient Volume	30 Percent	20-29 Percent
Year 1	$21,250	$14,166.67
Year 2	8,500	5,666.67
Year 3	8,500	5,666.67
Year 4	8,500	5.666.67
Year 5	8,500	5,666.67
Year 6	8,500	5,666.65
Total Incentive Payment	$63,750	$42,500

Since pediatricians are qualified to participate in the EHR Medicaid Incentive Payment Program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirement.

5.1 Payments for Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation System (RAS). The TIN must be associated to the provider in the Illinois MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Note: Pediatricians receive 2/3 of the incentive payments above. For any given year that a pediatrician attests to 30% or more Medicaid encounters, the pediatrician shall receive the full incentive amount.

6 PAYMENT METHODOLOGY FOR ELIGIBLE HOSPITALS

Statutory parameters placed on Illinois Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

The last year that a hospital may begin to receive the Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

The EHR Medicaid Incentive Payment Program amount for each EH is calculated one time. The hospital aggregate incentive amount calculation is made using the equation outlined in the Final Rule, as follows:

> (Overall EHR Amount) times (Medicaid Share) where Overall EHR Amount Equals {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} times Medicaid Share Equals {(Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

For more information on the calculation of the EH incentive payment, please visit the following websites:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_TipSheet_MedicaidHospitals.pdf

http://healthinsight.org/Internal/docs/2012-07-18/medicaid_hosp_incentive_payments_tip_sheets.pdf

Historically, the Illinois Medicaid program has relied upon a fragmented, provider-driven delivery system. Looking ahead to the promise of national health reform and the expansion of the Medicaid program in 2014, Illinois is taking steps to move the Medicaid program toward a delivery system that integrates care, shares information across healthcare providers, and is focused on health outcomes—better health outcomes—for our enrollees.

The Illinois General Assembly recently enacted substantial and comprehensive Medicaid reform legislation (*Public Act 096-1501*) for Illinois. The *Act*, among other things, directs HFS to greatly expand participation in integrated and coordinated care programs to improve the quality and cost-effectiveness

of care provided to Illinois Medicaid beneficiaries (see SMHP Section 2.4.9 for more information on *Public Act 096-1501*). These objectives are consistent with those of the federal HIT initiatives and the development of EHRs.

Illinois Medicaid presently offers a voluntary managed care option to family plan (children and caretaker relatives) enrollees in selected parts of the state. In the suburban Chicago metropolitan area, non-Medicare aged or disabled beneficiaries will be enrolled with integrated care plans. That, however, is only the beginning. Illinois fully intends to develop a variety of accountable care organizations and other forms of coordinated care that will support healthcare reform.

Effective integrated and coordinated care relies on sharing and use of information. EHR is critical to both. The EHR Medicaid Incentive Payment Program initiative encourages the adoption of EHR technology and initiates MU of certified EHR technology. Hospital participation in the care integration and coordination initiatives of the Illinois Medicaid program will accelerate actual and meaningful use of EHR. Participation by hospitals in these coordinated care initiates will further promote the development of *HITECH* envisioned federal legislation supported by State policy.

The EH EHR Medicaid Incentive Payment Program schedule is designed to support the economic and efficient administration of the Illinois Medicaid program through providing an incentive to hospitals to participate in care integration and coordination initiatives of the Illinois Medicaid program. That incentive takes the form of more expeditious payment of the total incentive amount to EHs that cooperate with HFS to further coordinate care provided to Medicaid enrollees.

Definitions:

"Coordinated care participating hospital" means a hospital that is located in a geographic area of the state in which HFS mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program, as defined in 305 *Illinois Compiled Statutes* (*ILCS*) 5/5-30, that is one of the following:

(i) Has entered into a contract to provide hospital services to enrollees of the care coordination program.

(ii) Has not been offered a contract by a care coordination plan that pays no less than HFS would have paid on a fee-for-service (FFS) basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that HFS pays directly.

(iii) Is not licensed to serve the population mandated to enroll in the care coordination program.

"Medicaid Managed Care Entity (MMCE) participating hospital" means a hospital that is located in a geographic area of the state in which HFS offers enrollment with a MMCE as a voluntary option to beneficiaries of the Medical Assistance Program and that has entered into a contract to provide hospital services to enrollees of an MMCE.

EHR Medicaid Incentive Payment Program schedule for EHs:

Table 1: Hospital Incentive Payment Schedule

Percentage of the overall EHR amount to be paid, by payment schedule and year					
Payment schedule	Year				
	(1)	(2)	(3)	(4)	(5)
A	25%	25%	20%	15%	15%
B	40%	30%	20%	10%	0%
E	50%	40%	10%	0%	0%

Group A is comprised of hospitals that do not qualify for groups B or E-those in coordinated care areas that have not yet availed themselves of the opportunity to participate in efforts to improve the coordination of care of Medicaid enrollees.

Hospitals qualifying for the EHR Medicaid Incentive Payment Program will be paid under schedule (A) unless qualifying for an expedited schedule (B or E)—i.e., the schedule applicable to the first class description into which the hospital falls.

Table 2: Hospital Payment Schedule by Hospital Class

Hospital class	Payment schedule
Pediatric specialty hospitals.	E
CAHs.	E
Hospitals operated by the Cook County Health and Hospitals System.	E
Hospitals operated by the University of Illinois at Chicago.	E
Hospitals that are both a coordinated care participating hospitals and an MMCE participating hospital.	E
Coordinated care participating hospitals that are in an area in which:	
—Both an MMCE and a mandatory coordinated care program operate.	B
—Only a mandatory coordinated care program operates.	E
MMCE participating hospitals that are in an area in which:	
—Both an MMCE and a mandatory coordinated care program operate.	B
—Only a voluntary coordinated care program operates.	E
Hospitals located outside of Illinois that are either a coordinated care participating hospitals or an MMCE participating hospital.	E
Hospitals in areas where neither an MMCE nor a mandatory coordinated care program operate.	B
All other hospitals.	A

An applicant hospital will be notified of its eligibility for, and the amount of, the incentive payment. In that same notice, the hospital will be informed if it qualifies for an expedited payment schedule.

All EHs will receive all of the incentive payments to which they are entitled. This 5-year period is allowed in federal law (42 CFR 495.310(f)(1). The payment is provided over a minimum of a 3-year period and maximum of a 6-year period.) Illinois' proposed disbursement schedule is fully in compliance with the regulation.

Note that as of June 15, 2011, of the 223 acute care hospitals with which we do business and that may potentially qualify for payments (the 10 percent test notwithstanding), only 22 of them fall into group A. Moving from group A to another group is entirely within the control of a hospital.

Hospitals that during the five-year payment period, qualify for a different payment schedule will, to the extent permissible under federal regulation, have their remaining payments adjusted to line up with the new schedule.

7 ADOPT, IMPLEMENT AND UPGRADE

Proof of adoption, implementation or upgrade of Certified Electronic Health Record Technology is required for year one of the EHR Medicaid Incentive Payment Program.

Proof includes one of the following types of documentation:

- Contract
- Software license
- Receipt or proof of acquisition
- Purchase order or invoice
- Lease
- Receipt for Training – evidence of cost or contract

An EP or EH receiving an incentive payment may be asked to provide additional documentation during a pre or post-payment audit. All documentation supporting the information the EP or EH attests to should be kept for 6 years.

8 MEANINGFUL USE

Second year providers will receive an e-mail when they become eligible to register for the second year of the incentive program. When registering for year two, providers will still need to review their federal information and enter their CMS assigned registration ID.

Providers and hospitals must ensure that their Medicaid registration and certification and/or license are up to date as well. Providers will be unable to complete their registration until this information is up to date within MMIS system.

Information required for attestation for meaningful use measures varies based on the measure. It is highly recommended that providers familiarize themselves with the required objectives prior to beginning data entry. Some objectives will have only a yes/no question. The information on Core and Menu Meaningful Use Measures can be found at the following CMS websites:

- **General Stage 1 Information** – Provides general information about Stage 1 Meaningful Use.
  - **2013 Stage 1 meaningful use**
  - **2014 Stage 1 meaningful use**

- **Stage 1 EP Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Stage 1 Meaningful Use measure per measure. Provides definitions.
  - **2013 EP Stage 1 meaningful use specifications**
  - **2014 EP Stage 1 meaningful use specifications**

- **Stage 1 EH/CAH Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet Meaningful Use measure per measure. Provides Definitions.
  - **2013 EH Stage 1 meaningful use specifications**
  - **2014 EH Stage 1 meaningful use specifications**

- **General Stage 2 Information** – Provides general information about Stage 2 Meaningful Use.
- **Stage 2 EP Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Stage 2 Meaningful use measure per measure. Provides definitions.
- **Stage 2 EH/CAH Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet Meaningful Use measure per measure. Provides definitions.

In the **Stage 1 meaningful use regulations**, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria. This original timeline would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013.

This criteria was modified with **Stage 2 legislation** and again in the **Flexibility Rule**, effective October 1, 2014. The table below illustrates the progression of meaningful use stages from when a Medicaid provider begins participation in the program.

1st Pymt Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

- *3-month EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.*

Note: Stage 3 can not occur until program year 2017 at the earliest. In 2014, providers who received their first payment in 2011 or 2012 can again attest for Stage 1, provided they can not fully implement 2014 Edition CEHRT for the EHR reporting period due to delays in 2014 Edition CEHRT availability. All other providers would meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year.

In the first year of participation, providers must demonstrate meaningful use for a 90-day EHR reporting period; in subsequent years, providers will demonstrate meaningful use for a full year EHR reporting period (an entire fiscal year for hospitals or an entire calendar year for EPs) except in 2014, which is described below.

Providers who participate in the Medicaid EHR Incentive Programs are not required to demonstrate meaningful use in consecutive years as described by the table above, but their progression through the stages of meaningful use would follow the same overall structure of two years meeting the criteria of each stage, with the first year of meaningful use participation consisting of a 90-day EHR reporting period. Providers who do not demonstrate meaningful use by October 1, 2014 (and each subsequent year) may be subject to Medicare payment adjustments.

8.1 For 2014 only

In 2014, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period.

For Medicare providers, this 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR).

For Medicaid providers only eligible to receive Medicaid EHR incentives, the 3-month reporting period is not fixed, where providers do not have the same alignment needs.

CMS permitted this one-time three-month reporting period in 2014 so that all providers upgrading to 2014 Certified EHR Technology would have adequate time to implement their new Certified EHR systems. Later in 2014, the Flexibility Rule allowed additional options for 2014 attestations.

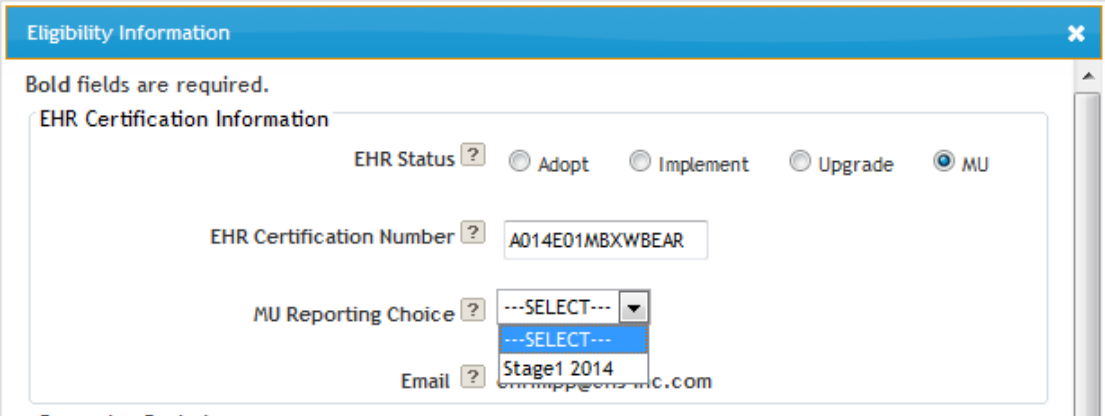
As shown in Table 3 below, if providers could not fully implement 2014 Edition CEHRTs for the EHR Reporting period in 2014 due to delays in 2014 Edition CEHRT availability, they could attest using a 2011 Edition CEHRT or a combined 2011 & 2014 Edition CEHRT. Providers who attested using the 2011 Edition CEHRT would be attesting to 2013 Stage 1 objectives and measures, regardless of Stage. Providers who attested using the combined 2011 & 2014 Edition CEHRT could attest using several different reporting options dependent on Stage.

Table 3—Proposed CEHRT Systems Available for Use in 2014			
If you were scheduled to demonstrate:	**You would be able to attest for Meaningful Use:**		
	Using 2011 Edition CEHRT to do:	**Using 2011 & 2014 Edition CEHRT to do:**	**Using 2014 Edition CEHRT to do:**
Stage 1 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* —OR— 2014 Stage 1 objectives and measures*	2014 Stage 1 objectives and measures.
Stage 2 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* —OR— 2014 Stage 1 objectives and measures* —OR— Stage 2 objectives and measures*	2014 Stage 1 objectives and measures* —OR— Stage 2 objectives and measures.

* Only providers that could not fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

Providers attesting for Medicaid in 2014 will see a new section, EHR Certification Information, on the Eligibility Information screen in the eMIPP application. First participation year providers will select the appropriate EHR status (MU will be the only option in all other years) and enter their EHR Certification Number. The eMIPP application will identify the CEHRT Edition and provide the appropriate MU Reporting Choices in a droplist. The appropriate MU Upload PDF files will also be made available in the meaningful use tab.

In the example shown below, the EHR Certification Information section of a first-year participation year screen is shown with MU selected and a 2014 Edition CEHRT entered. Since the provider is attesting for the first time, they are attesting for Stage 1. As a result, Stage 1 2014 is the only MU Reporting Choice provided (see Table 3).



8.2 Public Health reporting

EPs and EHs are required to participate in Public Health reporting (unless exclused from all reporting options) in order to achieve meaningful use.

8.2.1 Stage 1

- If a provider selects the exclusion for both the immunizations measure and the syndromic surveillance measure, they must complete four additional menu set objectives. Other than this scenario, Stage 1 requires at least one public health measure must be chosen from the menu set objectives.
- Providers must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data.
    - The test does not have to be successful.
    - The test must include the transfer of either actual or dummy data to the public health agency.
    - The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period.
- The Illinois Department of Public Health (IDPH) requests notice at least 30 days prior to the end of the MU reporting period to test.

8.2.2 Stage 2

- Since the Immunizations measure is a core measure in Stage 2, there is no additional requirement a public health menu set measure be chosen.
- The provider must complete their "registration of intent" with IDPH within 60 days of the start of the EHR reporting period and ongoing submission was achieved.
- Registering intent may be made via IDPH's **Meaningful Use Reporting System (MURS) web site**.
- Providers only need to register intent once, with IDPH, to indicate their intent to initiate ongoing submission of data to meet a public health objective. If in subsequent years of participation, providers have not progressed into testing and validation or ongoing submission (i.e. production) status, the documentation of the initial registration of intent may be used for attestation.
- The measure will also be considered met if:

    - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.
    - Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.
- The measure will not be met if the provider:
    - Fails to register their intent by the deadline
    - Fails to participate in the onboarding process as demonstrated by failure to respond to IDPH written requests for action within 30 days on two separate occasions.

For more information about public health reporting for meaningful use, visit:

http://www.illinois.gov/sites/ILHIE/Pages/publichealth.aspx

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PublicHealthRegistry_Tipsheet-.pdf

8.3 Core and Menu Objectives

Stage 1 established a core and menu structure for objectives that providers had to achieve in order to demonstrate meaningful use. Core objectives are objectives that all providers must meet. There are also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate meaningful use.

For many of the core and menu objectives, exclusions were provided that would allow providers to achieve meaningful use without having to meet those objectives that were outside of their normal scope of clinical practice. Under the original Stage 1 criteria, EPs had to meet 15 core objectives and 5 menu objectives selected from a total list of 10. Eligible hospitals and CAHs had to meet 14 core objectives and 5 menu objectives selected from a total list of 10.

Stage 2 retains this core and menu structure for meaningful use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised. We expect that providers who reach Stage 2 in the EHR Incentive Programs will be able to demonstrate meaningful use of their Certified EHR Technology for an even larger portion of their patient populations.

Some new objectives were also introduced for Stage 2, and most of these were introduced as menu objectives for Stage 2. As with the previous stage, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside their normal scope of clinical practice.

To demonstrate meaningful use under Stage 2 criteria:

- **EPs must meet 17 core objectives and 3 menu objectives selected from a total list of 6, or a total of 20 core objectives.**

- **Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives selected from a total list of 6, or a total of 19 core objectives.**

8.4 New Objectives & New Measures

Though most of the new objectives introduced for Stage 2 are menu objectives, EPs and eligible hospitals each have a new core objective that they must achieve. CMS believes that both of these objectives will have a positive impact on patient care and safety and are therefore requiring all providers to meet the objectives in Stage 2.

New Stage 2 Core Objectives:

For EPs only: Use secure electronic messaging to communicate with patients on relevant health information.
For EHs and CAHs only: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

Stage 2 also replaces the previous Stage 1 objectives to provide electronic copies of health information or discharge instructions and provide timely access to health information with objectives that allow patients to access their health information online.

Stage 2 Patient Access Objectives:

For EPs only: Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.

For EHs/CAHs only: Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital.

For additional information on Patient Access, see the **Patient Access Tipsheet**.

In addition, the Stage 2 criteria place an emphasis on health information exchange between providers to improve care coordination for patients. One of the core objectives for both EPs and eligible hospitals and CAHs requires providers who transition or refer a patient to another setting of care or provider of care to provide a summary of care record for more than 50% of those transitions of care and referrals. Additionally, there are new requirements for the electronic exchange of summary of care documents:

- For more than 10% of transitions and referrals, EPs, eligible hospitals, and CAHs that transition or refer their patient to another setting of care or provider of care must provide a summary of care record electronically.

- The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care must either:

    a. Conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or
    b. Conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.

There are also new Stage 2 menu objectives for EPs, eligible hospitals, and CAHs:

- Record electronic notes in patient records
- Imaging results accessible through CEHRT
- Record patient family health history
- Identify and report cancer cases to a State cancer registry **(for EPs only)**
- Identify and report specific cases to a specialized registry (other than a cancer registry) **(for EPs only)**
- Generate and transmit permissible discharge prescriptions electronically (eRx) **(new for eligible hospitals and CAHs only)**
- Provide structured electronic lab results to ambulatory providers **(for eligible hospitals and CAHs only)**

Finally, there are new Stage 2 measures for several objectives that require patients to use health information technology in order for providers to achieve meaningful use. CMS believes that EPs, eligible hospitals, and CAHs are in the best position to encourage the use of health IT by patients to further their own health care.

Under the Stage 2 core objectives to provide patients the ability to view online, download and transmit their health information, more than 5 percent of patients seen by the EP or admitted to an inpatient (Place of Service 21) or emergency department (Place of Service 23) of an eligible hospital or CAH must view, download, or transmit to a third party their health information.

Under the Stage 2 core objective to use secure electronic messaging to communicate with patients on relevant health information, a secure message must be sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients seen by an EP during the EHR reporting period.

8.5 Meaningful Use Reporting Data

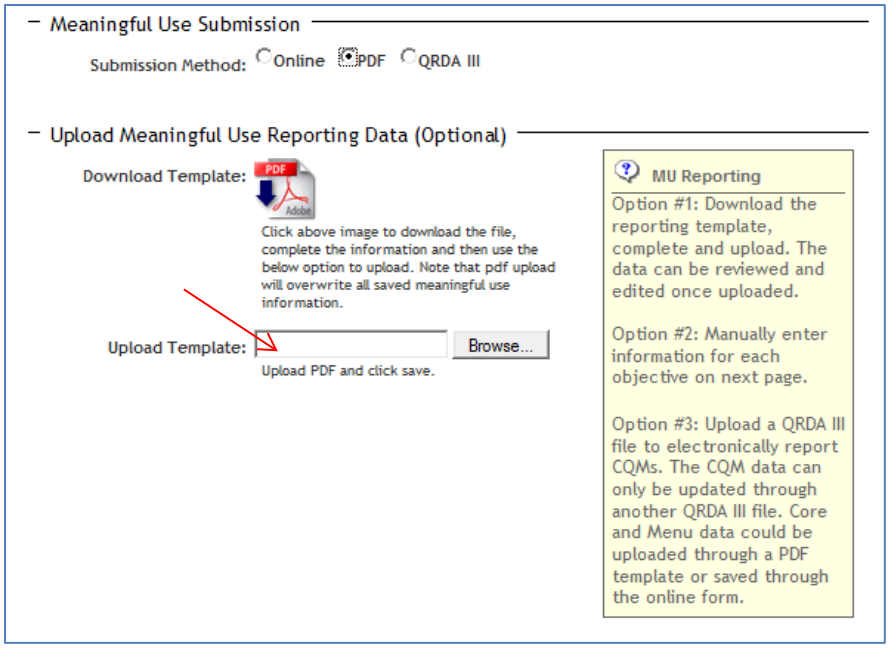
There are three methods by which to enter meaningful use data. Select eMIPP's Meaningful Use tab and click on the MU document for the appropriate submission year. On the MU Overview tab, a heading called "Meaningful Use Submission" lists three options; Online, PDF and QRDA III.

8.5.1 Online submission

The first method is to enter and submit the data online, through the website. Select "Online" as the submission method and enter data for objectives on the following screens.

8.5.2 PDF submission

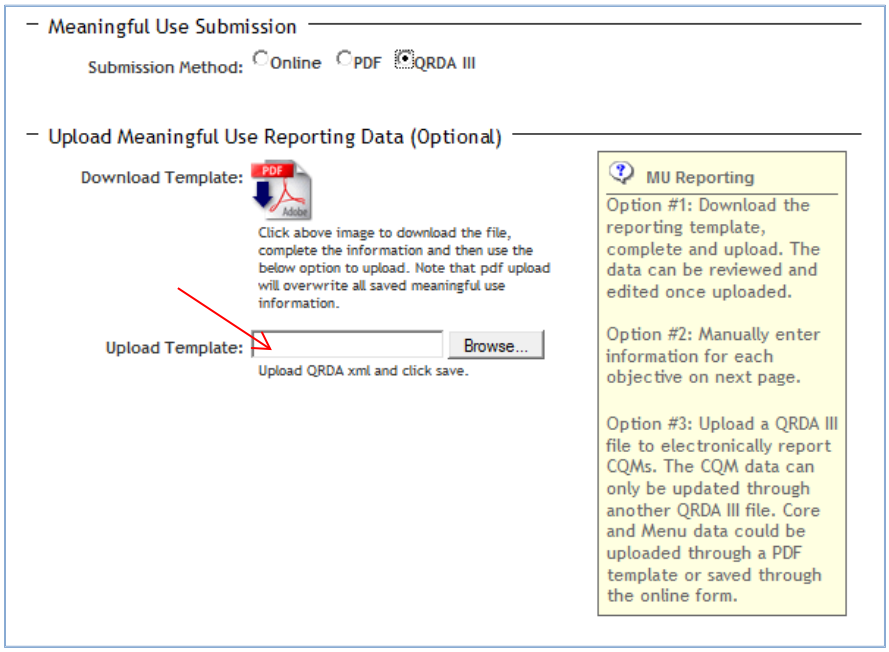
The second method (shown below) allows the user download a .pdf template to your computer to complete and upload. This method allows entry of MU data off-line and at the user's convenience. Providers can simply upload the document on the MU Overview Tab when finished.



The system will automatically populate the online version with all of the data entered in the PDF. You will now be able to review and make any changes to your data from the online form.

8.5.3 QRDA III submission

A third submission method became available in late March 2014, QRDA III. If a provider's EHR system is capable of exporting meaningful use CQM data to a QRDA III format, the QRDA III file may be uploaded directly into eMIPP (see below). Core and Menu data must be entered "online" or via a PDF file.



For additional information see **CMS' informational document on QRDA III**.

8.6 Clinical Quality Measures

8.6.1 CQMs for 2013

For additional information about CQMs for 2013, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CQM_Through_2013.html

8.6.2 CQMs 2014 and Beyond

Although clinical quality measure (CQM) reporting has been removed as a core objective for both EPs and eligible hospitals and CAHs, all providers are required to report on CQMs in order to demonstrate meaningful use. Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way.

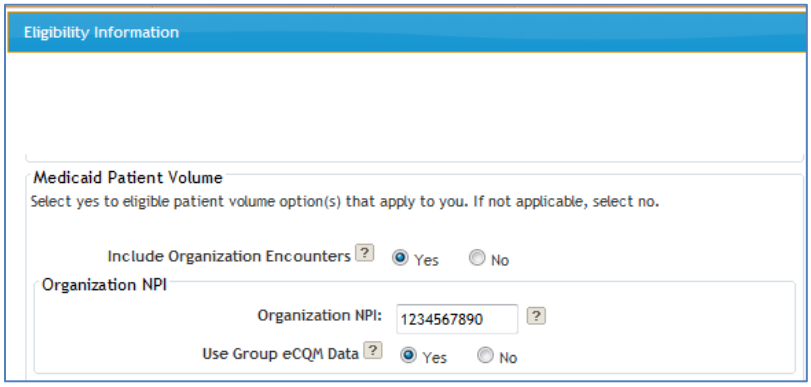
- **EPs must report on 9 out of 64 total CQMs.**
- **Eligible hospitals and CAHs must report on 16 out of 29 total CQMs.**

For more information on 2014 Clinical Quality Measures, please visit:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

8.6.3 Medicaid eCQM reporting

Although States are not required to implement eCQM reporting for Medicaid EHR incentive programs, it is allowed for the States to invoke this option. Illinois has chosen to allow Medicaid EHR incentive program eCQM reporting.

The provider has two options available for eCQM reporting; **Group** eCQM (QRDA III) reporting or **Individual** eCQM (QRDA III)reporting. When completing the Eligibility Information tab, assuming the provider has previously selected "Include Organization Encounter"= YES, a section titled Organization NPI appears as shown below. Below the data field "Organization NPI" is a question, "Use Group eCQM Data" (YES,NO). If you select YES, you have chosen Group eCQM reporting. If you select NO, you have chosen Individual eCQM reporting.



8.6.3.1 Group eCQM Reporting – Additional Considerations

- Providers must have reported Stage 1 MU for at least one year before using group eCQM reporting.
- For the submitting provider, the MU Core and Menu data is saved from the web form, and the CQM data is saved from the QRDA III file.
- For other providers in the group, only CQM data is saved from the QRDA III file. The existing MU Core and Menu data is maintained.
- The group QRDA III file upload:
  - Is not saved if there is existing CQM data loaded via an Individual QRDA III upload
  - Updates existing CQM data if it was loaded via a group QRDA III file
  - Clears all existing CQM data loaded via web forms or PDF upload, and saves only the CQMs on the QRDA III group file.
- If providers choose to upload a PDF after the group QRDA IIII file is uploaded:
  - The data for Core and Menu categories will be uploaded/overwritten from the PDF
  - CQM data will not be updated from the PDF
- If providers choose to update the MU data from the web form after the group QRDA III file is uploaded:
  - Core and Menu categories can be edited from the web form.
  - CQM data will be read-only and will not be editable from the web form.
  - On saving the MU form, only the Core and Menu will be updated.
- If providers choose to upload another group QRDA III file after the first group QRDA III file is uploaded:
  - Only the submitter of the first group QRDA III file is allowed to upload another group QRDA III file.
  - The new group QRDA III file is not a replacement file. It will update existing CQMs and save new CQMs.
- If providers choose to upload an individual QRDA III file after the group QRDA III file is uploaded:
  - All the CQMs loaded from the group QRDA III file are discarded.
  - Fresh CQMs are loaded from the individual QRDA III file
- Group CQM data are read-only on the screens.
- Groups may submit eCQM data multiple times until the first individual provider has attested.
  - Only the original NPI identified on the first eCQM upload is allowed to upload updates.
  - Updates of eCQM data is NOT a replacement file
  - All previously uploaded data will be kept unless changed.
- If a group wants to delete a specific CQM already uploaded then the CQM should be sent in another group QRDA III file with zeroes in the denominator.
- CQMs may be reported by a group with a single or multiple reports received by eMIPP, from one provider then applied to all members of the group.
- To qualify for group reporting a provider must be a member of the group on the attestion date.
- The group's "Organization NPI" must be "active" in MMIS on the attestation date.
- The first verified member of a group to submit a group QRDA III report must have entered and saved the group's eligible encounter information BEFORE sending the QRDA III CQM data set to assure that the group NPI is valid for this provider.
- The first verified member of a group that submits the group QRDA III report sets the CQM MU reporting period for the group in calendar/program year 2014.
- If a provider joins a group the provider is not eligible for "Group" MU reporting the first year of membership; except for calendar/Program year 2014 and the provider joined before the 90 day MU reporting window.
- Individual providers must report their first year of MU using their individual provider MU data, not group data.

- When State adjudicators find eCQM data to be non-compliant, then all members of the group are denied or rejected.
- If a group is rejected then each member of the group must re-attest to assure that all MU information is correct for the "fixed" registration.
- If eCQMs are accepted at the time of the first provider's attestation then the other members will never be rejected based on eCQM compliance because of CQM edits at time of submission. If the provider attempts to attest and submit prior to eCQMs being compliant for the group, the system will not accempt the submission and the provider will receive an error message.

8.6.3.2 Individual eCQM Reporting – Additional Considerations

- Providers must have reported Stage 1 MU for at least one year before using eCQM reporting.
- Individual providers may submit eCQMs multiple times until the individual provider has attested:
  - Updates of eCQM data are NOT replacement files. All previously uploaded data will be kept unless modified.
  - Providers have to enter a start and end date of their MU reporting period from the screen upon clicking on the save button. The start and end date from the QRDA file is ignored.
- An individual QRDA III upload:
  - Removes all prior CQM data uploaded via web form, PDF or Group QRDA III and loads fresh CQM data.
  - Only updates the existing CQM data loaded from an earlier individual QRDA III file.
  - Has no Core or Menu data. Core and Menu measures are loaded from the web form.
- If providers upload a group QRDA III file after an individual QRDA III file is uploaded:
  - No CQM data is saved from the group QRDA III file.
- If providers upload a PDF file after an individual QRDA III file is uploaded:
  - No CQM data is saved from the PDF file.
  - Core and MU data is saved from the PDF file.
- If providers edit data from the web form after an individual QRDA III file is uploaded:
  - All the data from the web form is saved, over-writing any existing data.
  - All the CQM data is now marked as 'Saved from web form'.

8.6.4 Reporting Clinical Quality Measure Data to CMS (Medicare)

Medicare eligible providers and hospitals must electronically report to CMS (Medicaid EPs and hospitals that are eligible only for the Medicaid EHR Incentive Program will electronically report their CQM data to their state). There will be a variety of options for providers to electronically report their CQMs.

EPs can electronically report CQMs either individually or as a group using the following methods:

- Physician Quality Reporting System (PQRS)—Electronic submission of samples of patient-level data in the Quality Reporting Data Architecture (QRDA) Category I format. EPs can also report as group using the PQRS GPRO tool. EPs who electronically report using this PQRS option will meet both their EHR Incentive Program and PQRS reporting requirements.

- CMS-designated transmission method—Electronic submission of aggregate-level data in QRDA Category III format.

Eligible hospitals and CAHs will electronically report their CQMs in the QRDA Category I format through the infrastructure similar to the EHR Reporting Pilot for hospitals, which will be the basis for an EHR-

based reporting option in the Hospital Inpatient Quality Reporting program. They may also submit aggregate-level data in QRDA III format.

For more information about electronically reporting CQMs to CMS, please visit **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Electronic_Reporting_Spec.html**

9 PROVIDER REGISTRATION AND ATTESTATION

9.1 Minimum System Requirements

For best results, the computer used for registration and attestation should meet the minimum system requirements stated below.

1. The recommended windows resolution is 1024 x 768.
2. The computer must have a Java Run Time Addition (JRE)
3. The eMIPP system is designed to run on Internet Explorer 8.0 and above.
4. If you are using Internet Explorer 10.0, you can adjust the browser settings In order to maximize the eMIPP module. Open the "Tools" Menu and select the "Compatibility View" Settings option and enter the eMIPP Module URL in the 'Add this website' option.
5. The eMIPP module uses pop-up menus that need to be displayed. In order for the module to display these correctly, the user will need to ensure that the Pop-up Blocker is turned off. To turn Pop-up Blocker on or off, follow these steps:
    - Open Internet Explorer, and then click on the "Tools" menu located at the far right hand side of your browser's Tab Bar.
    - When the drop-down menu appears, select the *Pop-up Blocker* option.
    - A sub-menu will now appear. Click on the option labeled *Turn Off Pop-up Blocker*.

9.2 Registration and Attestation Checklist

☐ Medicaid enrollment is up-to-date
☐ MEDI user name and password
☐ CMS assigned Registration ID (assigned when registering at the CMS site)
☐ CMS EHR Certification ID (see the CMS Certified EHR Technology web page)
☐ Eligible Professional Patient Volume Calculation worksheet completed; patient volume requirement met
☐ If attesting to Adopt, Implement or Upgrade (AIU) of an EHR, has documentation to support AIU of a certified EHR product, which must be one of the following:
- Contract
- Software license
- Receipt or proof of acquisition
- Purchase order or invoice
- Lease
- Receipt for Training – evidence of cost or contract

☐ If attesting for meaningful use, Meaningful Use Reporting Data template completed

9.3 CMS Registration

Both EPs and EHs are required to begin by registering at the CMS EHR Registration and Attestation System.

CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at **http://www.cms.gov/EHRIncentivePrograms/**.

The guides below will help you register and attest for EHR Incentive Programs. These official guides provide easy instructions for using the Federal CMS Medicare and Medicaid Registration & Attestation System (RAS), helpful tips and screenshots to walk you through the process, and important information that you will need in order to successfully register and attest. Please download the guide that best fits your needs:

- **Registration User Guide for Medicaid Eligible Professionals**
- **Registration User Guide for All Eligible Hospitals**

Additional User guides may be found on CMS' Registration and Attestation web page.

What is needed to register?

1. National Plan and Provider Enumeration System (NPPES) web user account, user ID and password
2. NPI of the individual provider
3. Payee Tax Identification Number (SSN or FEIN)
    - If payee is a Group (Group NPI, Name, TIN)
4. Email address
5. Business Name, Address, Phone, Zip + 4
6. Answer to which program you wish to attest to? Medicare or Medicaid
7. ONC Certified Electronic Health Record Technology Certification ID

EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select the Medicare or Medicaid incentive program (a provider may switch from one to the other once during the incentive program prior to 2015).

If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the RAS to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

After the initial registration, the provider does not need to return to the RAS before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the RAS annually to attest to meaningful use before returning to the Illinois EHR Medicaid Incentive payment system to attest for the Illinois EHR Incentive Program.

The RAS will assign the provider a CMS Registration Number and electronically notify HFS of a provider's choice to access Illinois' Medicaid EHR Incentive Program for payment.

9.4 Attestation – Registration with eMIPP

After registering with the CMS EHR Registration and Attestation System, providers must register at the HFS Medicaid Login portal **https://medicaid.illinois.gov** to access the eMIPP system. The provider must be enrolled and active in Illinois Medicaid system to complete the attestation process.

What you will need to login:

- User name and Password for the HFS Medicaid Login Portal
- User name and Password for MEDI
- CMS Registration ID for the provider you are attesting for.

If the provider entry does not match with what IL Medicaid has on file, an error message with instructions will be returned.

1. After successful log in to the eMIPP system, the provider will be asked to view the Federal Information that will be displayed with pre-populated data received from the CMS EHR Registration and Attestation System. To make corrections to the information, providers must visit the CMS EHR Registration and Attestation System website to make these changes and submit. Providers will need to wait for at least one business day before these changes are received in the eMIPP system.

2. The provider will then be asked to attest to the patient volume characteristics and EHR details including their EHR Status and EHR Certification number. Multiple practice locations can be typed and uploaded as a document. Organization NPI is needed to include organizational encounters. For FQHC/RHC, Charity Care and Sliding Fee Scale encounters are needed in addition to the Medicaid encounters.

3. Before submitting the attestation for state review, provider will be asked to upload required documentation and electronically sign the HFS disclaimer page. See Appendix A for the Attestation Disclaimer Language for EPs and Appendix B for the Attestation Disclaimer Language for EHs.

4. Upon submission of the electronic attestation and receipt of the required documentation, HFS will validate the attestation and adjudicate for payment. The payment will be issued by the Office of the Illinois State Comptroller.

5. Once the payment is disbursed to the eligible TIN, Federal CMS EHR Registration and Attestation System will be notified by Illinois Medicaid that a payment has been made.

Note: HFS will be conducting regular reviews of attestations and incentive payments as part of the audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should keep their supporting documentation on file for at least six years to support the audit requirement.

9.4.1 Troubleshooting

9.4.1.1 Web Browser Troubleshooting:

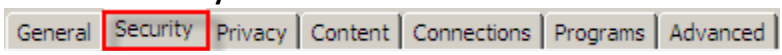
It is recommended that you use Microsoft Internet Explorer (IE) 8 or 9 to access the EHR registration system. If you have trouble using the EHR registration system, review these settings in IE 8.

From the desktop icon for IE 8:
Right Click on Internet Explorer Icon 

and click on **Properties.**

OR from inside IE 8:
Click on the **Tools** menu and go to **Internet Options**.

1) Select the **Security** tab.



2) Next click on 

3) Verify that the following settings have either been **Enabled** or **Prompted**:

In the "ActiveX controls and plug-ins" section:

Binary and script behaviors
- ○ Administrator approved
- ○ Disable
- ◉ Enable

Download signed ActiveX controls
- ○ Disable
- ○ Enable (not secure)
- ◉ Prompt (recommended)

Only allow approved domains to use ActiveX without prompt
- ○ Disable
- ◉ Enable

Run ActiveX controls and plug-ins
- ○ Administrator approved
- ○ Disable
- ◉ Enable
- ○ Prompt

Script ActiveX controls marked safe for scripting*
- ○ Disable
- ◉ Enable
- ○ Prompt

In the "**Downloads**" section:

Font download
- ○ Disable
- ◉ Enable
- ○ Prompt

9.5 Attestation Deadlines

Attestation deadlines for Illinois' EHR Medicaid incentive program are as follows:

2014 PROGRAM YEAR

- Eligible Professionals (EP) – March 31, 2015
- Eligible Hospitals (EH) – December 31, 2014

2015 PROGRAM YEAR

- Eligible Professionals (EP) – March 31, 2016
- Eligible Hospitals (EH) – December 31, 2015

10 HELP DESK INFORMATION

If you need additional support, please use the contact information below.

Issue	Contact
Login issues, Medi issues, insufficient Medi access issues	Email **HFS.medicaid-login@illinois.gov**. Medi/security staff will respond
eMIPP questions, Illinois Medicaid enrollment/eligibility questions,policy questions: EHR Help Desk	Phone **(877)782-5565 (select option 8)** or email **hfs.ehrincentive@illinois.gov**. HFS Medical Programs staff will respond.
Regional Extension Center (REC) help desk	Phone 1-855-MUHELP1 (or 1-855-684-3571)
Entrust (certificate issues, Entrust password issues)	State CMS Help Desk (1-800-366-8768)

For all other issues, please email HFS at:

- **hfs.ehrincentive@illinois.gov**

11 AUDIT INFORMATION

11.1 Medicaid Audits

EHR Incentive Program Medicaid Audits for the State of Illinois will be conducted by the Department of Healthcare and Family Services, Office of the Inspector General, Bureau oof Medicaid Integrity.

Any eligible professional (EP), eligible hospital (EH) or critical access hospital (CAH) attesting to and receiving an EHR incentive payment through the Illinois Medicaid EHR Incentive Program may be subject to a Medicaid audit.

It is the provider's responsibility to maintain the proper documentation that supports the meaningful use claims and the clinical quality measures submitted during attestation. Documentation supporting provider eligibility and Medicaid volume calculations also must be retained. It is recommended that EPs, EHs, and CAHs should retain all supporting attestation documentation in both electronic and paper format. If retaining screenshots, make sure all protected health information has been blackened out. To demonstrate that electronic documents have not been manipulated, save in a version that is not able to be manipulated such as PDF. Documentation supporting attestation should be kept for six years post-attestation.

11.1.1 Documentation to save:

- Office of the National Coordinator (ONC)-certified EHR software
    - Screenshot or other applicable document of certified health IT product list certification ID number for the version of software referenced during attestation
    - Documentation to prove acquisition/purchase/lease of ONC-certified EHR software. Examples include:
        - Contract documents
        - Documents supporting Invoice
        - Documents supporting Purchase Order
        - Lease documents
        - License documents
    - Practicing Locations – A list of all locations in which EP encounters occurred
    - Other Supporting Documents
- Hospital payment calculation
    - Documents supporting Cost Reports
    - Hospital calculation worksheet
- Eligibility requirements
    - Reports that support calculations of Medicaid and total patient encounter volumes, explanations of how and when they were generated
    - Documentation to support the number of unique patients seen by the EP
    - Group definitions, including a listing of the individual members of a group, patient volume reporting periods used, and the locations used to accumulate the group encounters

    - Documentation showing an FQHC or RHC is led by a Physician Assistant, if a Physician Assistant is requesting eligibility in the program
- Meaningful use achievement: *The provider must keep enough supporting documentation for each objective/measure to verify the numeric and other information supplied in the attestation. Examples of supporting documents that may be appropriate are listed below:*
    - Meaningful use dashboard reports showing provider achievement of core and selected menu measures, and screenshots or other applicable documents used to verify the date the reports were run
    - Documentation to support any exclusions taken for any meaningful use measure
    - Screenshot or other applicable document that verifies the EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period
    - Screenshot or other applicable document that shows the clinical decision support (CDS) rule was enabled (Stage 1) or that five clinical decision supports rules were enabled (Stage 2), dated prior to the beginning of the EHR reporting period
    - Clinical summary for a patient
    - Description of how/when (timeframe after visit) a clinical summary is given to the patient
    - Documentation to support exchange of key clinical information: what documentation was sent, name of the entity to whom the test was sent, the software and version of the EHR used by the receiving entity and a response from the receiving entity if the test was successful (effective for meaningful use attestations for 2010-2012 only as revised per Stage 2 legislation, effective 2013)
    - HIPAA Security risk analysis, including:
        - Physical inspection report
        - List of security deficiencies and how they were mitigated
        - Standards followed when conducting security risk analysis
        - How is encryption/security of data at rest addressed? (Stage 2)
    - Screenshot or other applicable document that verifies that drug formulary was enabled, dated prior to the beginning of the EHR reporting period (Stage 1)
    - Name of the formulary vendor (for example: Surescripts)
    - List of the types of clinical lab tests incorporated into CEHRT
    - Screenshot or other applicable document of lab order, dated during the EHR reporting period
    - Patient list, description of how the patient list was generated and for what purpose
    - Email sent to Illinois Department of Public Health (IDPH) with test file for submission of electronic data
    - IDPH letter verifying test of electronic data was submitted or that ongoing transmission is occurring in a production mode
- List of top five recipients of eRx and a Screenshot or other applicable document of the top five from the e-prescribing vendor (for example: Surescripts)
- For program year 2014, if claiming a lesser certification (less than 2014 CEHRT) per the 2014 Flexibility rule, provide proof of vendor delays or other documentation supporting the selection of the lesser certification.

Utilization of the information above does not guarantee that the EP will pass a CMS or State of Illinois audit. For more information on audits: **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Attestation.html**

APPENDIX A – EP ATTESTATION DISCLAIMER LANGUAGE

Providers will need to accept the following disclaimer language in order to submit their attestation.

Eligible Professionals:

You are about to submit your attestation for Eligible Health Records (EHR). Please make sure if you have uploaded one of the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use (Submit one from list below)
    - Contract
    - Software license
    - Receipt or proof of acquisition
    - Purchase order or invoice
    - Lease
    - Receipt for Training – evidence of cost or contract
2. Required only if you are attesting to Meaningful Use: Proof of compliance with the EHR submission measure, which states that "[c]apability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice"
    - The Illinois Comprehensive Automated Immunization Registry Exchange (iCare) registry email stating that the provider has attempted a test of the EHR capabilities.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested to by the Provider or Facility should be kept for 6 years.

I certify that the information submitted for Clinical Quality Measures was generated as output from an identified certified EHR technology. The information submitted is based on the knowledge and information provided by me, the Eligible Professional or is submitted on behalf of the Eligible Professional and the Eligible Professional has affirmed that the information provided is true, accurate and complete to the best of my knowledge. The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures that are applicable to the EP. The information submitted includes information on all patients to whom the measure applies. As a meaningful EHR user, at least 50% of the Eligible Professional's patient encounters during the EHR reporting period occurred at the practice/location given in the Eligible Professional's Attestation information and is equipped with certified EHR technology.

I understand that I, the Eligible Professional must have, and retain, documentation to support my eligibility for incentive payments and that the Illinois Department of Healthcare and Family Services may ask for this documentation. I further understand that the Illinois Department of Healthcare and Family Services will pursue repayment in all instances of improper payment. I certify that I, the Eligible Professional have not received Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

APPENDIX B – EH ATTESTATION AND DISCLAIMER LANGUAGE

Eligible Hospitals and Critical Access Hospitals:

You are about to submit your attestation for Eligible Health Records (EHR). Please make sure if you have uploaded one of the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use (Submit one from list below)
    - Contract
    - Software license
    - Receipt or proof of acquisition
    - Purchase order or invoice
    - Lease
    - Receipt for Training – evidence of cost or contract
    - Hospital Calculation Worksheet
2. Required only if you are attesting to Meaningful Use: Proof of compliance with the EHR submission measure, which states that "[c]apability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice"
    - The Illinois Comprehensive Automated Immunization Registry Exchange (iCare) registry email stating that the provider has attempted a test of the EHR capabilities.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested to by the Provider or Facility should be kept for 6 years.

I certify that the information submitted for Clinical Quality Measures was generated as output from an identified certified EHR technology. The information submitted is accurate to the knowledge of and on behalf of the Eligible hospital or CAH. The information submitted is based on the knowledge and information provided by the Eligible Hospital or CAH, is submitted on behalf of the Eligible Hospital or CAH, and the Eligible Hospital or CAH has affirmed that the information provided is true, accurate and complete to the best of my knowledge. The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures that are applicable to the Eligible Hospital or CAH. The information submitted includes information on all patients to whom the measure applies. For Clinical Quality Measures, a zero was reported in the denominator of a measure when an Eligible Hospital or CAH did not care for any patients in the denominator population during the EHR reporting period.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Illinois Department of Healthcare and Family Services may ask for this documentation. I further understand that the Illinois Department of Healthcare and Family Services will pursue repayment in all instances of improper payment. I certify that I (the Eligible Hospital) am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

APPENDIX C – TOOLKIT REVISION HISTORY

Topic/Subtopic	Page	Revisions	Revision Date
Table of Contents	2	Updated topics and page numbers	*11/19/2014*
1.1.1 Websites	3	Added and updated links	*11/19/2014*
1.1.3 Regional Extension Centers	4	Moved CHITREC info next to IL-HITREC (formatting)	*11/19/2014*
2 Background	4	Updated links; modified tabs examples listed in last paragraph	*11/19/2014*
3.3 Qualifying Providers by Type and Patient Volume	7	Minor formatting (table color)	*11/19/2014*
4.1.1.1 Definition of an Eligible Professional Medicaid Encounter	8	Revised definition to Stage 2 language, which includes zero-pay encounters (the services no longer must be paid by Medicaid).	*11/19/2014*
4.1.2.1 Groups - Additional Considerations	9	Added subtopic to document how eMIPP handles various scenarios regarding groups and patient volume (encounters).	*11/19/2014*
4.1.5.1 Definition of an Eligible Hospital Medicaid Encounter	8	Revised definition to Stage 2 language, which includes zero-pay encounters (the services no longer must be paid by Medicaid).	*11/19/2014*
8 Meaningful Use	19	Updated links; added links to cover 2013/2014 meaningful use options	*11/19/2014*
8 Meaningful Use	20	Modified text to include Flexibility rule information	*11/19/2014*
8 Meaningful Use	20	Updated "Stage of Meaningful Use" table to match Flexibility Rule	*11/19/2014*
8.1 For 2014 Only	21	Added text detailing the CEHRT options provided by the Flexibility Rule. Added Table 3.	*11/19/2014*
8.1 For 2014 Only	22	Added example of "Eligibility Information" section of the Eligibility tab revised by new coding for the Flexibility rule.	*11/19/2014*
8.2 Public Health Reporting	22	Created new subtopic (8.2 Public Health Reporting) to more specifically address Stage 1 testing vs. Stage 2 testing requirements for public health objectives.	*11/19/2014*
8.4 New Objectives & New Measures	24	Added link to Patient Access Tipsheet	*11/19/2014*
8.5 Meaningful Use Reporting Data	25-26	Adding subtopics to define the 3 submission options (Online, PDF, QRDA III eCQM). Added screenprints to demonstrate.	*11/19/2014*
8.6 Clinical Quality Measures	27	Added and updated links	*11/19/2014*
8.6.3 Medicaid eCQM reporting	27	Added subtopic (8.6.3 eCQM reporting) to detail Group vs. Individual eCQM reporting options. Included screen print for example.	*11/19/2014*
8.6.3.1 Group eCQM Reporting - Additional Considerations	28-29	Added subtopic (8.6.3.1) to list how eMIPP handles numerous new scenarios created with Group eCQM reporting	*11/19/2014*
8.6.3.2 Individual eCQM Reporting - Additional Considerations	29	Added subtopic (8.6.3.2) to list how eMIPP handles numerous new scenarios created with Individual eCQM reporting	*11/19/2014*
9.3 CMS Registration	31	Added link for Additional User Guides	*11/19/2014*
9.4 Attestation - Registration with eMIPP	32	Removed 2013 from section header	*11/19/2014*
10 Help Desk Information	35	Reformatted information; added email address for Medi/security issues	*11/19/2014*

Topic/Subtopic	Page	Revisions	Revision Date
11 Audit Information	36-37	Added section on Medicaid Audit information, including examples of documents to save.	*11/19/2014*
Table of Contents	2	Updated topics and page numbers	*3/10/2015*
8.2.1 Public Health Stage 1	22	Added information regarding selection exclusions of PH measures	*3/10/2015*
8.2.2 Public Health Stage 2	22	Added information regarding registration of intent	*3/10/2015*
9.5 Attestation Deadlines	34	Added complete section	*3/10/2015*
10 - Help Desk Information	34	Added Entrust information to contact list	*3/10/2015*
11 Audit Information	36	Added information regarding documentation needed for choosing lesser CEHRTS per flexibility rule options	*3/10/2015*
Appendix C - Toolkit Revision History	39	Added complete section	*3/10/2015*